2020 HEALTH VIRTUAL MEETING

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Session 6 - Direct Contracting and Other Models: How CMS, Providers, and Employers Continue to Challenge the Status Quo

June 9, 2020

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Session Overview

Introductions

direct contracting

- Shared savings (risk)
- Bundled payments
- Reference-based pricing
- Direct primary care
- Network replacement

Direct Contracting

- New payment model from the Centers for Medicare and Medicaid Services (CMS)

Q&A

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Introductions

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Introductions

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direct contracting

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Vocabulary

- Provider = physicians, medical groups, facilities, mid-level practitioners, etc. – term will be used broadly to refer to an entity that provides health care
- Employer = typically self-insured with a traditional TPA arrangement
- Third-party administrator (TPA) = administers benefits for self-insured employers
- Direct Contracting = new payment model from CMS
- direct contracting = describes payment arrangements between employers and providers

Resources


Provider Payment Arrangements, Provider Risk, and Their Relationship with the Cost of Health Care
October 2015


Insurance Risk and Its Impact on Provider Shared Risk Payment Models
January 2018
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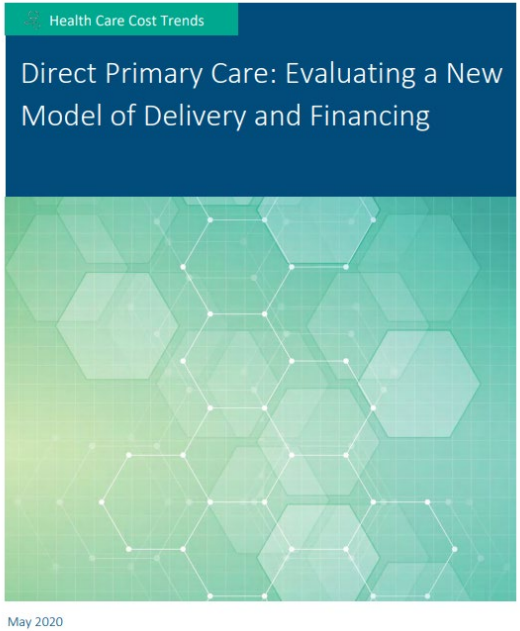

Health Care Cost Trends
Direct Primary Care: Evaluating a New Model of Delivery and Financing
May 2020

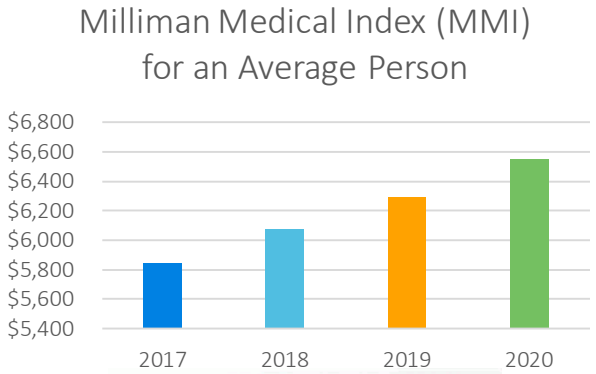
direct contracting - Motivations

Employers

- Primary motivation = reduce costs
- Additional motivations:
  - Increase transparency
  - Enhance benefits
  - Improve employee wellness and satisfaction
  - Cede risks

Providers

- Primary motivation = pursuit of the ‘quadruple aim’
- Additional motivations:
  - Market share
  - Reward for efficiency / pay for value
  - Administrative



Shared Savings

Definition: financial agreement whereby providers are rewarded (or penalized) for their performance against established targets for claims and quality outcomes

- Common form of value-based contract
- Usually covers total cost of care (sometimes including Rx)
- Can be simple to execute agreement between employer and provider
- Typically relies on fee-for-service infrastructure

Challenges:

- Availability of data
- Difficulty in understanding risk management provisions (e.g. large claims, risk adjustment)
- Prospective targets

Bundled Payments

Definition: a fixed-price agreement for a provider to perform a procedure or manage a condition and take responsibility for contractually defined related services for a specified period

- Pre-operative and post-operative care may be included
- Financial responsibility creates incentive to eliminate wasteful services

Challenges:

- Administrative complexity
- Understanding inclusions/exclusions
- Prospective vs. retrospective methodologies
- Data!
- Scale

Reference-Based Pricing (RBP)

Definition: a FFS payment methodology whereby the amount paid to a provider is capped – most commonly set as a function of the Medicare fee schedule (e.g. 180% of Medicare)

- Intended to encourage employee consumerism
- Provider may or may not agree to the payment terms
- Bottom-up approach (vs. top-down approach of billed charges and discounts)
- Scope of services subject to RPB may be limited

Challenges:

- Employee education
- Balance billing
- Identifying an appropriate reference price

Direct Primary Care (DPC)

Definition: financial agreement whereby primary care providers agree to fixed monthly payments for negotiated primary care services

- DPC practices not typically part of TPA provider network
- Fees generally range from $25 (child) to $85 (older adult)
- Usually covers total cost of care (sometimes including Rx)
- SOA report found statistically significant reductions in emergency department visits and ‘other’ outpatient facility claims costs (e.g. hospital pharmacy, pathology/lab services)

Challenges:

- Included/excluded services
- Risk adjustment and ROI measurement
- Adverse selection
- Scale and physician capacity
- Still in its infancy

Network Replacement

Definition: employer health plan that uses a provider's network instead of a TPA's network

- Employer-specific fee schedule
- Care management/utilization management functions may be assumed by provider
- Could incorporate several other direct contracting strategies

Challenges:

- Geographic concentration
- Scale
- Administrative complexity
- Market share

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Direct Contracting

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Direct Contracting - Motivations

Centers for Medicare and Medicaid Services (CMS)

- "Medicare Fiscal Cliff" – As of the 2020 Trustees Report, the estimated depletion date for the Hospital Insurance (HI) trust fund is projected to be 2026.
- Continuation/Improvements of CMMI Accountable Care Organizations (ACO) Models:
  - 2012-2016 Pioneer ACO Model
  - 2015-2020 Next Generation ACO (NGACO)
- Reduce Medicare expenditures while preserving or improving quality
- Shift financial risk to healthcare entities and providers

Providers, Health Plans, Insurers, and Healthcare Organizations

- "Medicare Fiscal Cliff" – The depletion of the HI trust fund could lead to a 10% reduction in scheduled payments for Medicare services.
- NGACO participants looking to continue in a CMMI ACO Model
- Highest level of risk/reward opportunities
- High Needs Population Direct Contracting Entities (DCEs)

What is Direct Contracting?

A new CMMI model with three voluntary payment options aimed at reducing cost and improving the quality of care for Medicare beneficiaries.

Professional	– lower-risk at 50% shared savings/(losses)
Global	– full-risk at 100% shared savings/(losses)
*Geographic**	*– total cost of care (TCOC) risk*

** Geographic Population-Based Payment Model Option has not been released.*

Direct Contracting and MSSP Enhanced ACO

Professional

- 5,000 Minimum Beneficiaries
- 50% Shared Savings/(Losses)
- No Discount
- Savings/(Losses) Capped at
  - 50% from 0-5% of benchmark
  - 35% from 5-10% of benchmark
  - 15% from 10-15% of benchmark
  - 5% from 15%+ of benchmark
- Alternative Payment Options
  - Primary Care Capitation (7%)
  - Advanced Payment (PCC Only)
- 5% Quality Withhold (CI/SEP)
- Eligible for High Performers Pool
- Advanced APM starting in 2021

Global

- 5,000 Minimum Beneficiaries
- 100% Shared Savings/(Losses)
- 2-5% Discount from PY1 to PY5
- Savings/(Losses) Capped at
  - 100% from 0-25% of benchmark
  - 50% from 25-35% of benchmark
  - 25% from 35-50% of benchmark
  - 10% from 50%+ of benchmark
- Alternative Payment Options
  - Primary Care Capitation (7%)
  - Advanced Payment (PCC Only)
  - Total Care Capitation
- 5% Quality Withhold (CI/SEP)
- Eligible for High Performers Pool
- Advanced APM starting in 2021

MSSP Enhanced ACO

- 5,000 Minimum Beneficiaries
- Up to 75% Shared Savings
- 40% to 75% Shared (Losses)
- No Discount
- Savings Capped at 20% of Benchmark
- Losses Capped at 15% of Benchmark
- No Alternative Payment Options
- Quality Score Applied to Sharing Rate
- Advanced APM

Direct Contracting Entities

Standard DCEs

- Experienced organizations serving Medicare FFS beneficiaries (e.g. MSSP, NGACO, etc.)
- Voluntary and claims-based alignment

New Entrant DCEs

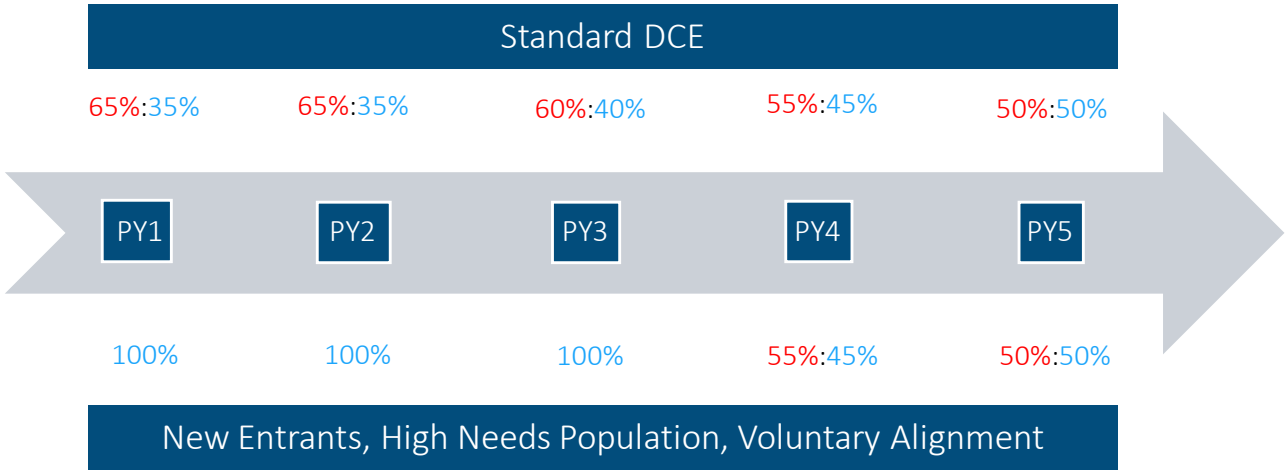
- Organizations with limited historical experience delivering care to Medicare FFS beneficiaries. Beneficiaries aligned via claims in any baseline year must not exceed 3,000.
- Primarily rely on voluntary alignment

High Needs Population DCEs

- Organizations that will serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries
- Voluntary and claims-based alignment

Benchmark Calculations

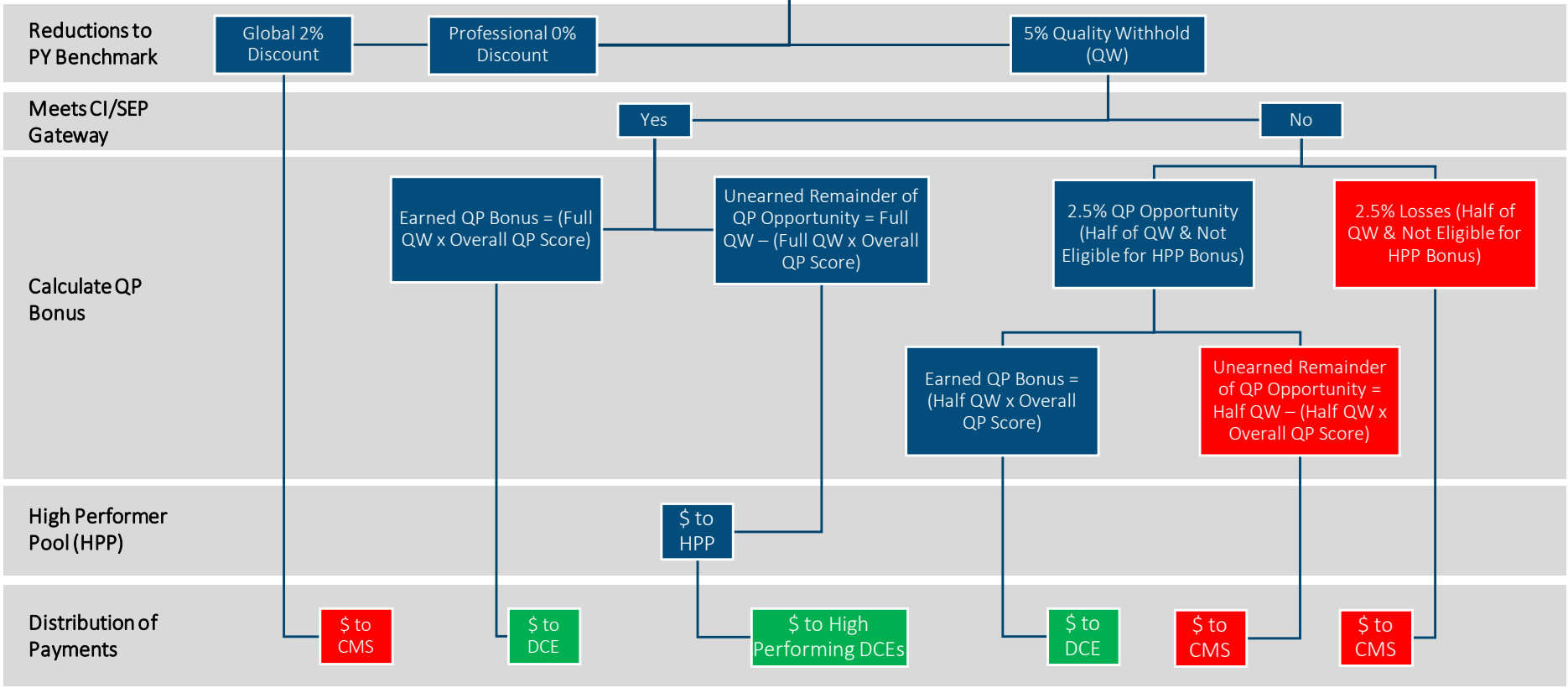
Historical[1] and Regional[2] (adjusted MA Rate Book)



[1] Historical base year weighting for the baseline period is 10%, 30% and 60% for CY 2017, CY 2018 and CY 2019, respectively.

[2] Regional benchmarks will be based on an adjusted MA Rate Book which will be used to create a beneficiary-weighted average of all counties in which the DCE has at least one beneficiary; the specifics of the adjusted MA Rate Book have not been finalized.

Performance Year Benchmark



High Performers' Pool (HPP)

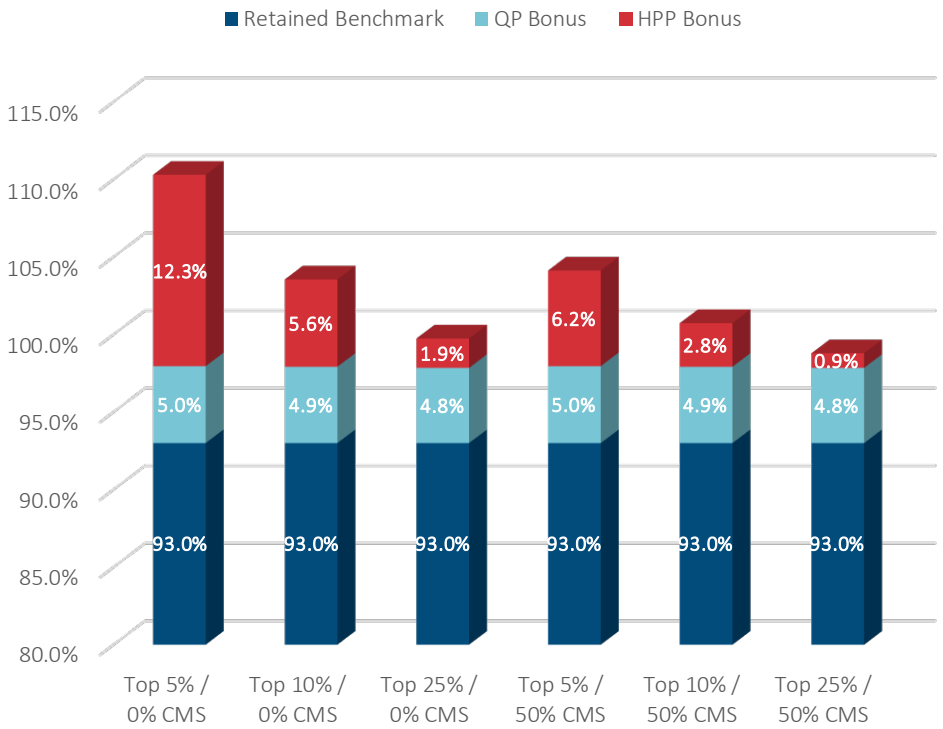
The HPP could have a significant financial impact to the highest performing DCEs.

Example using the 2018 MSSP PUF

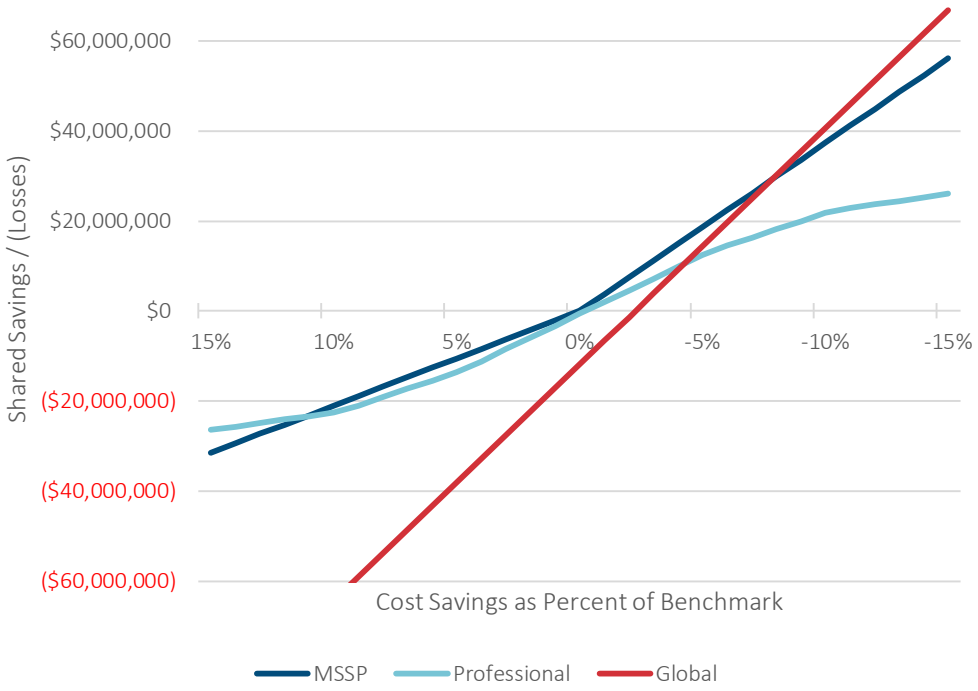
Top 5% of eligible high performing DCEs receive the HPP bonus. NOTE the top 5% of MSSPs in 2018 had a quality score of at least 98.4%.

1) CMS Retains 0% of HPP - DCE would receive an additional 12.3% HPP bonus, or 110.3% of the benchmark.

2) CMS Retains 50% of HPP - DCE would receive an additional 6.2% HPP bonus, or 104.1% of the benchmark.



Shared Savings/(Losses) Comparison



An ACO participating in Global DC would need to achieve savings in excess of 7.5% of the benchmark in Performance Year 1 before achieving a higher shared savings than an ACO in MSSP.

Assumptions

- 50,000 Beneficiaries
- $10,500 PBPY Benchmark
- 95% Quality Rating
- 2% Discount for Global DC
- No Impact for High Performers' Pool
- No Reduction from Capitated Agreements

Unknowns / Concerns

- Unknowns; waiting on financial specification papers from CMS
  1) Adjusted Medicare Advantage (MA) Rate Book
  2) Risk Adjustment Methodology
  3) High Performers' Pool (HPP)
- What's the impact of provider networks not joining DC?
- Will physicians be persuaded into joining DCEs thus leaving an existing MSSP?
- What's the impact of COVID19 on DC?
- What's the risk associated with Department of Insurance (DOI)? Will the DCE be required to maintain higher capital requirements?
- Is Medicare Advantage a better option?

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Medicare Advantage

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Medicare Advantage

- Advantages
  - Known Methodology
  - Escaping the “Performance Trap”
  - New Opportunities
- Challenges
  - Operational
  - Competitive

Key Advantages of Medicare Advantage

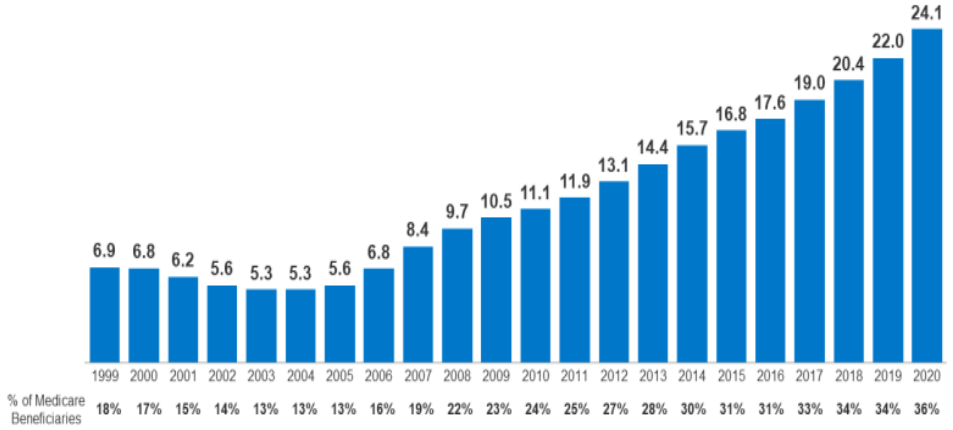
- Known Methodology
  - Benchmark rates, Risk score coding, Benefit design rules
  - Regulatory environment is well established, well understood, and consistent year to year
- No “Performance Trap”
  - Benchmarks are set independently of individual organizational performance
  - No benchmark reductions due a plan performing well / no “plateau” on savings
- Custom Benefit Designs
  - Provide additional value to membership
  - Incentivize appropriate behaviors

Key Advantages of Medicare Advantage

- New Opportunities
  - Rapidly growing market
  - Leveraging operational capacity into new lines of business

Figure 1

Total Medicare Advantage Enrollment, 1999-2020
(in millions)



NOTE: Includes cost plans as well as Medicare Advantage plans. About 68 million people are enrolled in Medicare in 2020.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2008-2020, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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Key Challenges of Medicare Advantage

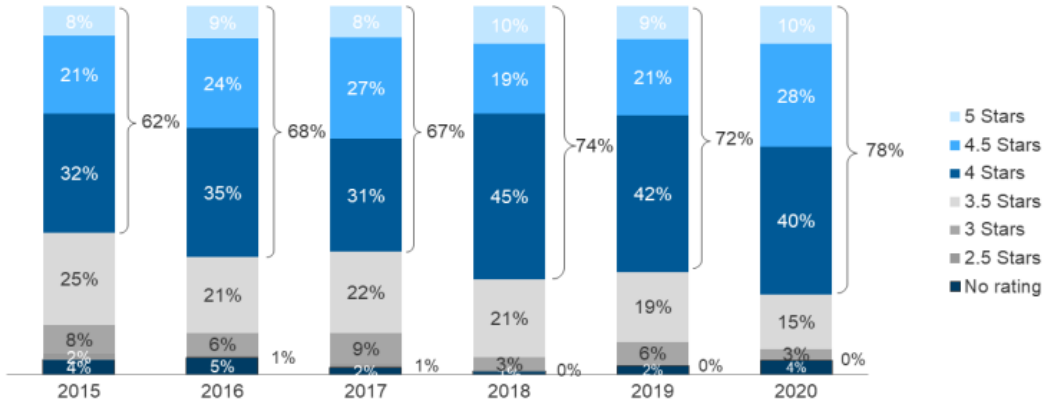
- Operational Challenges
  - Marketing
  - Provider Contracting
  - MA-specific Challenges
    - Star ratings
    - Coding - MA Coding Pattern Adjustment is a revenue hit of more than 6% compared to FFS
    - Sequestration

Key Challenges of Medicare Advantage

	MA Bid to Benchmark		Part D NABA	
	Average	Trend	Average	Trend
2012			$84.50	
2013			$79.64	-6%
2014			$75.88	-5%
2015			$70.18	-8%
2016			$64.66	-8%
2017	91.9%		$61.08	-6%
2018	91.9%	0%	$57.93	-5%
2019	88.0%	-4%	$51.28	-11%
2020	86.0%	-2%	$47.59	-7%
2021	84.8%	-1%		

Figure 11

Distribution of Medicare Advantage Enrollees by Plan Star Rating, 2015-2020



NOTE: Excludes SNPs, employer-sponsored group plans, HCPPs, PACE plans, and plans for special populations. Totals may not sum due to rounding. Less than 1% of enrollees were in plans with 2 stars during all years shown.

SOURCE: KFF analysis of CMS Medicare Advantage Landscape and Enrollment Files for 2015 – 2020.

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Key Considerations for Medicare Advantage

- Operational
  - Capital – How much access to capital do you have? What is your organizational tolerance for potential losses?
  - General – How difficult / expensive will it be to stand up a health plan that can succeed at all of the required functions?
- Competitive
  - Star Ratings – Can you achieve 4 stars?
  - Market Environment – What benefits are being offered at what premiums? How efficiently must you operate to offer a competitive product? Do you have a unique value proposition to offer?
  - Growth Potential – How have startup MAOs fared in the past? How many people are entering the Medicare market each year? How saturated is the MA market? How much growth is realistic in the first few years?
  - Administrative Overhead – How efficiently can you operate, and how much growth is required to achieve competitive admin levels?
  - Provider Contracting – What level of reimbursement levels can you negotiate compared to current carriers?

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COVID-19

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Q&A

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